Help in Hope Referral Form

Date of Referral:	- - (MM – DD – YYYY)	**HIH JOIN ID:**	
Program:		**County:**	

Participant Name:		DOB:		Age		Gender:	M ☐ F ☐
Hispanic/Latino ☐	Race:		Current School/Grade:				
For the most recent grading period, what grades did you get	☐ A ☐ B ☐ C ☐ D ☐ F	Have you been suspended from school? Have you been expelled from school?	☐ Yes ☐ No ☐ Yes ☐ No	Currently, what best describes your employment status? Not in labor force (not seeking work) ☐ Unemployed ☐ employed ☐ self-employed			
Legal Guardian:				Phone:			
Legal Guardian's relationship to client:							
Physical Address:			City:		Zip:		
Mailing Address:			City:		Zip:		

ADDITIONAL PARTICIPANT INFORMATION:			
Does the client speak English?	Yes ☐ No ☐	What is the primary language spoken in the household?	
Does the client have an Exceptional Designation (EC or IEP)?	Yes ☐ No ☐		
List any current medical problems:			
List all current medications:			
Does client have private medical insurance?	Yes ☐ No ☐		
Does client have Medicaid/ Health Choice?	Yes ☐ No ☐		
If "No," has parent/guardian applied for Medicaid or Health Choice?	Yes ☐ No ☐		
Enter the number of problems the client has experienced over the previous 12 months:			
Number of Runaways		☐ Unknown	

Number of Short-Term Suspensions		☐ Unknown
Number of Long-Term Suspensions		☐ Unknown
Number of Expulsions		☐ Unknown

Is there Juvenile Justice Involvement?				Yes ☐ No ☐
Is participation in this program court ordered?				Yes ☐ No ☐
Is participation in this program a part of a diversion plan/contract?				Yes ☐ No ☐
Court Counselor:		Phone:		Email:
Participant Risk Score/Level:		Participant Needs Score/Level:		

Problem Behaviors \ Risk Indicators:

INDIVIDUAL

- ☐ Bullying Behavior
- ☐ Negative Labeling/Bullied
- ☐ Crime/Delinquency (unreported & reported)
- ☐ Fighting/Assault/ Aggressive Behavior
- ☐ Fire Setting
- ☐ Impulsive/Risk Taking
- ☐ Mental Health Issues/Depression/ Anxiety/Temper Tantrums
- ☐ Poor Social Skills/Anti-social
- ☐ Run Away from Home
- ☐ Self-Mutilation
- ☐ Sexually Active
- ☐ Sexual Offense
- ☐ Sexual/Physical/Mental Abuse/ Victimization/ Trauma

INDIVIDUAL (continued)

- ☐ Substance Use (alcohol or drugs)
- ☐ Suicide Attempts
- ☐ Suicidal Ideation/Threats

FAMILY

- ☐ Excessive Dependence on Parents
- ☐ Family Conflict
- ☐ Lack of Discipline by Parent or Child is Ungovernable
- ☐ Siblings or Parent/Guardian on Probation or Incarcerated
- ☐ Substance Use in Home

SCHOOL

- ☐ Academic Failure/Behind Grade Level for Age
- ☐ Behavior Problems: Disruptive in Class/ Referrals to Office/ Suspensions

SCHOOL (continued)

- ☐ Truancy/Skipping School

PEER

- ☐ Gang Associate or Member; or Gang Involvement
- ☐ Negative Peer Associations/ Association with Aggressive Peers
- ☐ Typically Associates with Negative Older Persons

COMMUNITY

- ☐ Availability or Perceived Access to Drugs
- ☐ Disadvantaged/ Disorganized/ Impoverished Neighborhood
- ☐ Feeling Unsafe in Home Neighborhood
- ☐ High Crime Rate in Home Neighborhood

Please summarize the youth's history of developmental, learning, or mental health problems:

In what way could the agency assist the participant :

Referred By: ☐ Self ☐ Agency ☐ Relative/Friend ☐ Other (describe)

Referrer's Name

Agency

Address:

Home Phone **Work Phone:** **Work Fax:**

Email:

OTHER COMMENTS OR ADDITIONAL INFORMATION:

Please provide any additional information or further comments that could be helpful:

COMPLETION CHECKLIST & REFERRER SIGNATURE:

Before sending the referral, please check the following and sign below:

Please tick:

☐ All sections and information have been completed

☐ All reports and documents have been included

☐ The referrer has signed and dated the referral below. Unsigned referrals will not be accepted

☐ The customer and their legal guardian acknowledges and agrees to the referral being made

Referrer's Signature: **Date:**